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Medicare PART Documentation Doesn't Satisfy Medical Necessity

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Much confusion abounds regarding how to document the treatment of a Medicare patient. There are two main action steps that are required to become compliant. The first step is to read your Local Coverage Determination (LCD)[1] and Section 240 from Chapter 15 in the *Medicare Benefit Policy Manual*.[2] All of the documentation requirements are found in these two resources. LCDs can vary slightly throughout the nation; however, they are all based on Section 240, which is why it is good to read both documents.

Unfortunately, many DCs have told us they have never read or even heard of the LCD or Section 240, which we believe is a likely reason for the profession-wide struggle with compliance. As each document is only about 10 pages, concerns about complexity and Draconian rules are easily dispelled; that is, we are sure Medicare is not out to get us.

The second step is to embrace the essence of the requirements in your LCD. In other words, you cannot just read the LCD once; you have to *own* the LCD. And owning the LCD will bring you to the realization that reimbursement for treating Medicare patients is about managing spinal pain and related functional disability.

At present, Medicare only pays for spinal manipulation when the patient is suffering from a "significant neuromusculoskeletal condition" of the spine that is amenable to manipulation in a reasonable period of time. Therefore, for the diagnosis, use *ICD-9* codes that are accepted by Medicare and that reflect the symptom of pain your patient is experiencing.

It is important to embrace the fact that, in the eyes of Medicare, there is no such thing as a "painless" significant neuromusculoskeletal condition / subluxation of the spine that causes functional disability. Furthermore, it is important to embrace the fact that the *ICD-9* code, the significant neuromusculoskeletal condition, and the "subluxation" are really synonyms in the eyes of Medicare, which we explained in a recent article. [Read "The Medicare Hurdle That Continues to Block Our Professional Progress" by Drs. Seaman, Luce and Anthony Hamm in the April 9, 2012 issue for more information.]

PART and the Trouble It Causes

Identifying pain (P), asymmetries (A), range-of-motion abnormalities (R), and tissue tone (T) changes are a required component of Medicare documentation. It is common to believe that describing PART in the record functions to establish medical necessity for manipulative treatment that is reimbursable by Medicare. However, almost nothing could be further from the truth, and here is why.

Consider that pain (P) by itself can be minor and not physically limiting. Spinal asymmetries (A) can be present without pain and functional limitations. ROM changes (R) can be present without pain or functional limitations. Tissue tone changes (T) can be minor and present without pain or

functional limitations.

In other words, PART may or may not be clinically relevant. Irrespective of this problematic and somewhat confusing issue, we must still operationalize PART, as it is a required component of Medicare documentation. Below are two examples that explain how PART should be viewed.

First, consider a pain-free and fully functional 70-year-old male. It is certainly possible that we could identify asymmetries, range-of-motion abnormalities, and tissue tone changes; however, because this individual is pain-free and without functional disability, these PART findings do not establish medical necessity for treatment with manipulation according to Medicare. The patient does not have a significant neuromusculoskeletal condition and he does not have an applicable *ICD-9* code, so he does not have a reimbursable subluxation in need of manipulation.

Now take another 70-year-old with low back pain that occasionally radiates into the upper thigh, and who also has a history of heart disease and is a smoker. His pain limits his ability to exercise, do yard work, and enjoy his part-time work at the local golf course, which suggests that this patient has a significant neuromusculoskeletal condition.

At this point, however, we do not know the source of this patient's pain. It may be due to an abdominal aortic aneurysm (AAA), which is not a significant neuromusculoskeletal condition and is not amenable to manipulation. However, an appropriate examination and imaging results rule out the AAA, all of which must be documented in the record.

Next, a spinal exam leads to the provocation of this patient's pain, which means the spine is causal. This is a very important point. Medicare requires us to state in the record that the spine is "causal." We must further identify the offending vertebra and document that we have examined said vertebra via the PART requirement, which further suggests this patient has a manipulable lesion. In this case, the patient's symptoms, functional deficits, positive exam findings, and PART collectively function to establish medical necessity for treatment trial with manipulation.

Notice the difference in the two examples. In the first patient, PART is an incidental finding that is clinically irrelevant. In the second patient, PART by itself would not have established medical necessity; however, PART *in conjunction* with other documented pertinent clinical findings leads to the establishment of medical necessity for manipulative care that is both reimbursable and defensible.

The Take-Home

PART is commonly described in a vacuum, as if it is the key to effective Medicare documentation, which is not true. Medicare does not reimburse us for demonstrating PART. As described in this article, by itself, a thoroughly completed PART evaluation is clinically irrelevant unless the patient is suffering with a manipulation-responsive, spine-generated pain that is functionally disabling.

References

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2. Center for Medicare & Medicaid Services. *Medicare Benefit Policy Manual.* Chapter 15 – Covered Medical and Other Health Services. www.cms.gov/manuals/Downloads/bp102c15.pdf

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